Permission to Disclose Confidential Information

This form is used by organizations that collaborate with each other in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of coordinating care, delivering services, paying for services, and health care operations. This form complies with **[applicable state confidentiality law]**, federal privacy regulations for alcohol and drug records (42 CFR Part 2), and federal law on the privacy of education records (FERPA; 20 USC 1232g). **[States have separate statutory provisions for HIV-AIDS related information, so a statement may be inserted here, to this effect: This form is not for use for HIV-AIDS related information].** This form does not constitute an "authorization" under federal HIPAA regulations, though it contains many of the elements of such an authorization. This is because an "authorization" is not required for use and disclosure of protected health information when use and disclosure is for purposes of treatment, payment or health care operations (45 CFR 164.506).

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.

2. The person whose information may be used or disclosed is:

   Name: _____. Date of Birth: _____.

3. The information that may be used or disclosed includes (check all that apply):

   ☐ Mental health records
   ☐ Alcohol/Drug Records
   ☐ School or Education Records
   ☐ Health records
   ☐ All of the records listed above

4. This information may be disclosed by:

   ☐ Any person or organization that possesses the information to be disclosed
   ☐ The persons or organizations listed in Attachment A
   ☐ The following persons or organizations providing services to me:

   _____ _____
   _____ _____
   _____ _____
   _____ _____

5. This information may be disclosed to:

   ☐ Any person or organization that needs the information to provide service to the person who is the subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.
   ☐ The persons or organizations listed in Attachment A
   ☐ The following persons or organizations:

   _____ _____
   _____ _____
   _____ _____
   _____ _____

6. The purposes for which this information may be used and disclosed include:

- Evaluation of eligibility to participate in a program supported by the ____**[applicable funder, e.g. , a county government]**;
- Delivery of services, including care coordination and case management;
- Payment for services; and
- Health care operations such as quality assurance.

7. I understand that **[state]** and federal law prohibit persons that receive mental health, alcohol or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8. This permission expires (check applicable box):

☐ On _____ (date); or
☐ Upon the following event _____.

9. This permission is limited as follows:

☐ Permission only applies to records for the following time period: _____, ____ to _____, ____.
☐ Other limitation: _____.

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records as described in this document.

_____ _____
Signature Date

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is _____. I give permission to use and disclose my records as described in this document.

_____ _____
Signature Date

_____
Print Name

Attachment A

This permission to disclose records applies to the following organizations and those working at those organizations:

At this point, each organization that will use the form or to whom information might be disclosed should be listed, preferably by name, with space for "other" organizations to be listed if they are not on the form.

Notes to potential users:

1. **This form was prepared by John Petrila, J.D., based on consent form developed by Mr. Paul Litwak, J.D., one of the country's foremost experts on HIPAA.**
2. **This form does not provide legal advice. Whether a form modeled on this one meets legal requirements for the organization in question is a question best addressed to counsel to the organization.**
3. **The form should not be adopted for use without examining the specific laws referenced in the form, e.g. FERPA, HIPAA, 42 CFR and the applicable state confidentiality laws.**
4. **Note that state laws may affect who signs for a minor. Note also that 42 CFR requires a minor to sign for releases of information. Some states may also require a parental signature for the minor to obtain treatment. In those states, guidance from SAMHSA indicates that both the parent and minor must sign for release. *See* www.hipaa.samhsa.gov/download2/SAMHSA**